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Issue date: 31Jan2002

In the Matter of

LEONARD L. CLAY
Claimant

v.

STEVENS SHIPPING & TERMINAL CO.
Employer,
and
ABERCROMBIE, SIMMONS, GILLETTE
Insurer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest.

Case No.: 2000-LHC-2505

OWCP No.: 06-177323

APPEARANCES: Mr. Paul E. Gibson, Attorney
For the Claimant

Ms. Mary N. Morgan, Attorney
For the Employer/Carrier

BEFORE: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER

This case involves a claim filed by Mr. Leonard Clay for benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901 - 950, as amended ("the Act") due to an ankle injury he suffered on August 28, 1998, while working as a truck driver for Stevens Shipping & Terminal Company ("Stevens") in Charleston, South Carolina.

On June 13, 2000, the District Director forwarded to the Office of Administrative Law Judges a pre-hearing statement filed by the claimant's counsel. Pursuant to an Amended Notice of Hearing, dated September 15, 2000 (ALJ 1), I conducted a hearing on November 29, 2000 attended by Mr. Clay, Mr.

Gibson and Ms. Morgan. My decision in this case is based on the testimony presented at the hearing and all the documents admitted into evidence: CX 1 to CX 8, and EX 1 to EX 8.[1]

ISSUES

1. Whether Section 8 (c) (2) (loss of leg) or Section 8 (c) (4) (loss of foot) is the appropriate schedule provision for a partially disabling ankle injury.

2. Extent of disability.

3. Whether special payments should be included in calculating the average weekly wage for compensation for a scheduled injury.

SUMMARY OF EVIDENCE

While I have read and considered all the evidence presented, I will only summarize below the information potentially relevant in addressing the issues in this case.

Sworn Testimony

Mr. Leonard L. Clay
(TR, pages 20 to 39)

[Direct Examination] Mr. Leonard L. Clay is 52 years old, and has worked as a longshoreman for roughly 15 years. Prior to his injury, Mr. Clay had never had any ankle problems. On August 28, 1998, while lashing down some cargo chains, Mr. Clay injured his right ankle. When chains holding a large, heavy equipment pan gave way, Mr. Clay fell forward, bounced off a co-worker, then fell backward, twisting his leg and right ankle. Mr. Clay reported his injury and was sent to Work Site Partners for treatment.

After about two weeks, Work Site Partners referred Mr. Clay to Dr. Lowery. Being familiar with Dr. Lowery , Mr. Clay encouraged the Work Site Partners' referral. Dr. Lowery x-rayed Mr. Clay's ankle, then placed the ankle in a cast for roughly six weeks. After the cast was removed, Mr. Clay went to physical therapy.

Mr. Clay returned to work on November 9, 1998. He experienced persistent pain and continued treatment with Dr. Lowery. Eventually, Dr. Lowery performed surgery on Mr. Clay's ankle in June, 1999. Mr. Clay was already receiving temporary total benefits for a different shoulder injury, so he did not request any further benefits for the surgery. After the surgery, Dr. Lowery considered Mr. Clay's ankle healed.

[1] The following notations appear in this decision to identify specific evidence and other documents: ALJ - Administrative Law Judge exhibit, TR - Transcript of hearing, CX - Claimant's exhibit and EX - Employer's exhibit.

However, Mr. Clay could also expect long term pain. Mr. Clay has not returned to work, due to his shoulder injury.

Mr. Clay's ankle caused him problems when he would drive trucks. He experienced pain when he pressed down on the pedals, and had to shift himself so that he could drive with his left foot. His ankle burns when he walks too far. He does not take any prescription drugs, but takes over the counter pain medication, or the pain medicine prescribed for other injuries. The injury would present some difficulty for his working on the waterfront, because he must shift his weight off his injured ankle.

[Cross-Examination] Having previously seen Dr. Lowery for a toe injury, Mr. Clay indicated his preference for Dr. Lowery. Mr. Clay never requested another doctor. Dr. Lowery is currently treating Mr. Clay for another accident. When Dr. Lowery allowed Mr. Clay to return to work, he stated that Mr. Clay would continue to have pain.

The biggest problem that Mr. Clay has had with his ankle has been swelling and pain. Earlier, Mr. Clay had some problems with the ankle giving way, but physical therapy has stopped that. Since Dr. Lowery had released Mr. Clay to return to work, there has not been any problem with the ankle giving way. When he was cleared to return, Mr. Clay worked until February 1999, when he injured his shoulder. Mr. Clay had surgery on his ankle when he was out of work for another injury.

Mr. Clay again returned to his regular duties in January of 2000, and worked until he injured his back and left knee at work in August, 2000. Dr. Lowery has treated Mr. Clay for his August, 2000 knee injury. When Mr. Clay returned to work, he continued to have ankle pain. Mr. Clay stated that he still experiences incidents where he feels as if he has slipped or mis-stepped. When asked about his prior deposition testimony that his ankle had not given way in the past, Mr. Clay stated that his earlier testimony was accurate. He currently experiences pain and swelling, which is worse after extended use. Mr. Clay had already worked over 700 hours for the year 2000 before he was injured.

[Re-Direct Examination] Mr. Clay was examined by Dr. Jones for a second opinion on his ankle. He paid for the examination himself.

Documentary Evidence

Medical Records of Work Site Partners
(CX1)

Mr. Clay visited Work Site Partners from August 28, 1998 until September 2, 1998. His right ankle was swollen and the swelling extended two inches above the ankle. The diagnosis was ankle sprain. During this period, he was unable to walk on his right leg and used crutches. He experienced swelling in the medial and lateral aspects of his ankle.

Medical Records of Dr. Robert B. W. Lowery
(CX 2, CX 4, EX 6, and EX 7)

The record contains Dr. Lowery's office notes from his treatment of Mr. Clay from September 14, 1998 to November 5, 1999.

September 14, 1998 - In the initial examination, Dr. Lowery, a board certified orthopaedic surgeon, obtained information about Mr. Clay's accident including his comment that he felt a pop or break in his ankle. Dr. Lowery observed swelling over the lateral aspect of right ankle. The entire lateral side of the ankle was tender, with maximum tenderness at the syndesmosis in the interior talofibular region. Mr. Clay also had moderate tenderness over the sinus tarsi and midfoot, as well as minimal tenderness over the medial side. Dr. Lowery took x-rays, which did not reveal any significant bony abnormalities. Dr. Lowery's impression was a syndesmosis[2] injury or ankle sprain. To promote healing and allow Mr. Clay to function, Dr. Lowery placed the ankle in a walking cast for three weeks.

October 5, 1998 - Mr. Clay continued to experience pain and difficulty walking after the cast removal. He still had tenderness over the anterior syndesmosis and distal fibula; but there was no significant medial tenderness. X-rays did not show any signs of a fracture. Dr. Lowery prescribed three weeks of physical therapy.

October 26, 1998 - Mr. Clay finished physical therapy, but he needed to continue with dorsiflexion. He still experienced edema and pain, mainly over the medial malleolus and talonavicular joint. The examination revealed tenderness over the anterior talofibular and tibiotalar ligaments, with some mild edema. Dorsiflexion is approximately five degrees. Dr. Lowery recommended that Mr. Clay continue with physical therapy for two more weeks, and then return to full duty.

November 23, 1998 - Mr. Clay displayed good range of motion and mild tenderness. He had returned to regular duty.

February 19, 1999 - Mr. Clay was able to perform his duties at work but still experienced discomfort. He was not taking anti-inflammatory medicine to ease his pain. Mr. Clay continued to have tenderness over the distal fibula and talonavicular area, as well as decreased range of motion, particularly on dorsiflexion. Dr. Lowery ordered a three phase bone scan, and gave him a prescription for Naprosyn.

March 4, 1999 - The bone scan by Dr. Wesley Henry showed an abnormal soft tissue uptake in the right ankle, primarily in the medial malleolus. The pattern was not suggestive of osteomyelitis. Instead, the results may be attributable to mild hyperemia associated with the healing injury.

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[2] A type of fibrous joint in which the intervening fibrous connective tissue forms a ligament. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1623 (28th ed. 1994).

March 19, 1999 - Mr. Clay continued to have pain on the medial aspect of his ankle. The bone scan revealed uptake on medial side. On examination, there was no significant swelling, but pain continued on the medial side in the medial malleolus. Dr. Lowery's impression was a possible posterior tib tendon injury and medial ankle pain. He ordered an MRI scan of Mr. Clay's ankle. A recent shoulder injury would delay treatment because he would be required to be on crutches.

March 26, 1999 - The MRI report by Dr. Catherine Johnson showed the absence of marrow signal abnormality. Specifically, there was no abnormality in the medial malleolus to account for the increased radiotracer uptake in the bone scan. The lateral peroneal, medial flexor, and the posterior tibialis tendons were all intact. There was no evidence of signal abnormality within the fibers of the posterior tibialis tendon, or edema to suggest tendinitis or tenosynovitis. She concluded the study showed a normal ankle.

April 16, 1999 - Although the MRI did not reveal anything significant. Mr. Clay continued to have swelling over the medial ankle. Dr. Lowery suspected possible ankle synovitis,[3] noting the bone scan was "hot" on this side. Dr. Lowery prescribed an ankle injection. If the injection did not help, arthroscopy was probably the next approach.

May 21, 1999 - The ankle injection did not provide any significant improvement. Mr. Clay continued to have pain and tenderness along the anterior ankle region. Dr. Lowery believed that Mr. Clay probably had synovitis. Dr. Lowery discussed with Mr. Clay the options of either accepting his ankle as it is, or going forward with arthroscopy. After discussing the risks, Mr. Clay wanted to try the arthroscopy.

June 30, 1999 - Dr. Lowery performed arthroscopic surgery and confirmed synovitis of the ankle, with meniscoid lesion/adhesion. Mr. Clay had good articular cartilage throughout the ankle. Dr. Lowery found mild synovial changes medially, but distinct synovial changes on the anterolateral gutter with a large thick fibrotic adhesion from the anterior aspect of the tibia to the dorsal anterior aspect of the talus. A synovectomy was performed, and the adhesion/meniscal lesion was resected and shaven down. A mild synovectomy was performed anteriorly and anteromedially. There was no additional pathology found in either the medial lateral gutters or medial side.

July 7, 1999 - After the arthroscopic surgery, Mr. Clay continued to have some pain in his ankle, along with appropriate tenderness over the anterior aspect. At the same time, there was minimal swelling. Dr. Lowery placed Mr. Clay on light duty with the intention of returning him to full duty in a month.

August 11, 1999 - Mr. Clay experienced tingling in his foot from time to time, but the preoperative pain had been completely resolved. He had good range of motion and mild tenderness to palpation. Dr. Lowery released Mr. Clay to full duty.

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[3]Inflammation of the synovial (fluid sac surrounding a joint) membrane. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1645 (28th ed. 1994).

November 5, 1999 - Mr. Clay reported intermittent pain in his ankle several times a week, and some swelling. His ankle had good motion and good strength, with mild tenderness anteriorly and anterior laterally. Dr. Lowery agrees with Mr. Clay that he is as good as he is going to get. Mr. Clay has reached maximum medical improvement. Dr. Lowery assigned a 3% impairment to the lower extremity.

April 17, 2000 - Dr. Lowery reviewed Dr. Jones' examination and his 10% whole body disability rating of Mr. Clay. Dr. Lowery noted the absence of any distinct ligamentous laxity. So, the impairment rating of 3% to the lower extremity was based on Table 62 on page 83, noting mild arthritis and synovitis of the ankle which was "fairly mild and equated primarily to only pain."

Deposition of Dr. Robert B. W. Lowery
(EX 6)

In a November 20, 2000 deposition, Dr. Lowery provided further information about his treatment of Mr. Clay. With regard to the August 28, 1998 injury, Dr. Lowery first examined Mr. Clay on September 14, 1998. During his first exam, Mr. Clay was tender over the syndesmosis. The syndesmosis is the part of the ankle where the tibia and fibula come together proximal to the ankle, and the strong ligaments which tie the bones together. He x-rayed the leg and ankle, to be sure there was no fibula break. Dr. Lowery did not detect any instability. His initial impression was a syndesmosis injury and an ankle sprain. Dr. Lowery placed Mr. Clay in a walking cast, to allow the ligaments to heal while allowing Mr. Clay to get off his crutches and become more mobile.

When Mr. Clay returned, still complaining of trouble walking, Dr. Lowery x-rayed the leg again and found no fractures. He sent Mr. Clay to physical therapy. Mr. Clay continued to experience swelling, both medially and laterally in the ankle joint, during physical therapy.

Mr. Clay was allowed to return to full duty around November 16, 1998. He remained under Dr. Lowery's care, and had not reached maximum medical improvement. Mr. Clay continued to complain of pain in the distal most aspect of the syndesmosis, where the tibia, fibula, talus and calcaneus meet. When Mr. Clay was still having these problems in February, 1999, Dr. Lowery sent him for a phase 3 bone scan in March, 1999. The bone scan revealed a slight increased uptake on the medial side of the ankle, but not the lateral side where Mr. Clay experienced his pain. The uptake refers to an increase in bone turnover, and can indicate arthritic changes, a healing fracture, or infection. Dr. Lowery felt that this uptake was due to arthritis, but noted that it was on the opposite side of the ankle from Mr. Clay's symptoms.

Dr. Lowery next sent Mr. Clay for an MRI, which did not produce any significant results. Dr. Lowery felt that Mr. Clay was experiencing only inflamed tissue in the form of a meniscoid lesion, a tear of the anterior ligament which rubs against the talus and causes pain and swelling. Such a tear does not usually show up on MRIs. Dr. Lowery gave Mr. Clay a cortizone injection in his ankle, but it did not give him long term relief. Mr. Clay had not complained of any laxity in his ankle.

Because the cortizone injection did not provide long term relief, Dr. Lowery decided to perform arthroscopic surgery on the ankle to remove any synovitis or irritated areas. The surgery was performed on June 3, 1999 to clean up the ankle and removed irritated areas. Dr. Lowery found some scar tissue, synovitis, and a bit of arthritis but nothing unexpected. Mr. Clay did fair after the surgery, but still experienced pain, tenderness and swelling of the ankle.

Dr. Lowery allowed Mr. Clay to return to full duty on August 11, 1999. Dr. Lowery placed Mr. Clay at maximum medical improvement on November 5, 1999. Dr. Lowery has not seen Mr. Clay for his ankle since that date, but has seen him for other injuries.

Dr. Lowery assigned an impairment rating of three percent to the lower right extremity, based on Table 62 on page 83 of the AMA Guidelines for Impairment, Fourth Edition, Revised. This table relates to arthritis and is based on radiographic findings. A strict application of the guidelines would require a finding of a zero percent impairment. However, Dr. Lowery followed his surgical findings of arthritis in assessing a three percent impairment. Orthopedic surgeons have some leeway in assigning ratings that differ from the AMA Guidelines.

Dr. Lowery reviewed the independent medical evaluation of Dr. Jones. Dr. Jones used the AMA table for instability in Mr. Clay's ankle. Dr. Lowery disagrees with that finding, because he never found any instability in the ankle. If Mr. Clay had ankle instability then he would have expected to see symptoms of the ankle giving way. Throughout his treatment of Mr. Clay, Dr. Lowery did not observe any such symptoms.

Dr. Lowery is optimistic about Mr. Clay's ankle. He may experience some soreness, particularly in cold weather. Mr. Clay's arthritis is not progressive, and barring further injury there is no need for further treatment. Mr. Clay should have a good ankle for the long term.

Dr. Lowery has never had any specialized training in evaluation of permanent impairments. Dr. Jones' findings are based on pain primarily in the medial aspect of the ankle. However, Dr. Lowery found the pain to be mostly in the anterior and lateral aspects and due to inflammation rather than ligaments. Dr. Lowery characterized the pain as synovitis pain. Synovitis is an inflamation of the synovial line, and is different from arthritis. During the ankle surgery, Dr. Lowery found mainly synovitis and only "a little bit of arthritis."

Dr. Lowery extrapolated down from the lowest value on the impairment table to reach a 3 % impairment to the leg. This would equate to an impairment of 5% to the foot.

Report of Dr. Gregory Jones
(CX 3, CX 5 and EX 7)

On January 25, 2000, Dr. Gregory Jones, board certified in physical medicine and rehabilitation, reviewed the medical records from Work Site Partners and Dr. Lowery, examined Mr. Clay, evaluated ankle x-rays, and developed a second opinion concerning Mr. Clay's ankle injury. Mr. Clay's complaints were persistent right ankle pain and subjective weakness in the ankle. Upon examination, Dr. Jones noted Mr. Clay was 5' 10" and weighed 290 pounds. There was marked tenderness over the medial malleolar region and anterior talofibular tendon region. Bilateral ankle edema was found. There were no definite range of motion deficits, but Mr. Clay experienced significant pain on plantar flexion and dorsiflexion past 20 degrees. There was a 10 degree range of motion deficit for inversion, and a 5 degree deficit for eversion. Dr. Jones specifically observed, "no proximal leg or thigh symptoms, no low back pain complaints following injury 8/28/98." The x-rays showed medial malleolar degenerative changes of a mild nature, as well as a small calcaneus spur on the plantar aspect.

Dr. Jones agreed with Dr. Lowery that Mr. Clay can return to his usual duties without any specific restrictions. While there was no ligamentous instability noted, there is a moderate impairment, which could possibly be due to a neurologic compromise. Dr. Jones concluded Mr. Clay suffers a likely moderate impairment to the ankle due to ligamentous pain as found on clinical examination, leading to a corresponding impairment of 4% to the whole person, 10 % to the lower extremity, and 14% to the foot. Dr. Jones also recommended an EMG to assess the possibility of a nerve impairment. Mr. Clay has reached maximum medical improvement.

On February 17, 2000, Dr. Jones conducted an electromyogram. The bilateral peroneal and tibial motor nerve studies revealed slow amplitudes and borderline low conduction velocities. The F-responses for these nerves were within normal limits, but on the border of prolongation. All other tests were normal. The EMG did not reveal any evidence of definitive peripheral compressive neuropathy. At the same time, Dr. Jones believed there was some evidence of generalized sensory motor polyneuropathy of an unknown origin. Consequently, Dr. Jones would not add any additional impairment for nerve deficit. Finally, Dr. Jones re-affirmed his disability ratings for Mr. Clay. Dr. Jones agreed with Dr. Lowery that Mr. Clay had reached MMI on November 5, 1999 and was capable of performing his usual activities without restrictions.

Waterfront Employers Hours Display
(EX 8)

The hours display lists the number of hours that Mr. Clay has worked in longshore employment by year. It shows that Mr. Clay has worked greater than 700 hours in 1980-1983, 1995-1998, and 2000. In 1999 he was given credit for over 800 hours of workers' compensation time. Mr. Clay did not work any longshore hours from 1984 to 1987, and from 1988 to 1994.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the hearing, the parties stipulated to the following facts: a) the date of injury is August 28, 1998; b) on that day Mr. Clay injured his right ankle; c) at the time of the accident, an employer and employee relationship existed between Mr. Clay and Stevens Shipping & Terminal Company; d) the injury arose out of, and during, the course of this employment; e) all notices in this case were timely; and, f) Mr. Clay reached maximum medical improvement on November 5, 1999 (TR, pages 14 to 16).[4]

Mr. Clay's Disability

Under the Act, a longshoreman's inability to work due to a work-related injury is addressed in terms of the nature of the disability (permanent or temporary) and the extent of the disability (total or partial). Since Mr. Clay is seeking compensation for a work-related disability, he has the burden of proving, through the preponderance of the evidence, both the nature and extent of disability. *Trask v. Lockheed Shipbuilding Construction Co.*, 17 BRBS 56, 59 (1985).

Nature of Disability

The nature of a disability, permanent or temporary, is typically defined by the date of maximum medical improvement ("MMI"). *Trask*, 17 BRBS at 60. A claimant reaches MMI when the injuries from the work-related accident have stabilized and no further improvement is anticipated. *Thompson v. Quinton Enterprise, Ltd.*, 14 BRBS 395, 401 (1981) and *Dixon v. Cooper Stevedoring Co.*, 18 BRBS 25, 32 (1986). Any disability suffered by a claimant prior to MMI is considered temporary in nature. *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984). If a claimant has any residual disability after reaching MMI, then the nature of the disability is permanent. *Sinclair v. United Food & Commercial Workers*, 13 BRBS 148 (1979).

Based on the evidence in the record, the parties' stipulations, and the presumption under Section 20 (a) of the Act,[5] Mr. Clay suffered a work-related injury to his right ankle on August 28, 1998. Over the course of nearly a year, Mr. Clay underwent conservative therapy for his ankle pain. Then, in June

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[4]The parties also agreed that the average weekly wage in this case, without inclusion of special pay for vacation/ holiday and container royalties was $1,013.28, with a corresponding compensation rate of $675.52. The average weekly wage with the special pay items was $1,445.39 and a corresponding compensation rate of $835.74 (the maximum allowable compensation at the time). TR, pages 6 and 38.

[5]If a claimant establishes the existence of an injury and the occurrence of a work-related accident that could have caused the injury, then the courts and Benefit Review Board have interpreted Section 20 (a) of the Act, 33 U.S.C. § 920 (a), to invoke a presumption on behalf of a claimant that, absent substantial evidence to the contrary, the injury was caused by the work-related accident. In Mr. Clay's case, the evidence demonstrates that Mr. Clay suffered an accident at work when loosened cargo chains caused him to fall and twist his ankle on August 28, 1998 and he had a right ankle injury.

1999, Mr. Clay underwent arthroscopic surgery on his ankle. Eventually Dr. Lowery concluded no additional treatments would improve his situation. The parties have stipulated, and both Dr. Lowery and Dr. Jones agree, that Mr. Clay reached MMI on November 5, 1999. Consequently, I find the nature of any disability Mr. Clay may have in regards to his right ankle injury stemming from the August 28, 1999 work-related accident is permanent.

Extent of Disability

The extent of disability relates to the impact of an injury on an employee's wage earning capacity. If an injured employee is unable to return to any work, then the extent of his disability is total. On the other hand, if an injured employee retains the capability to earn a wage through work, then the extent of his disability is only partial. Following treatment, surgery, and therapy rehabilitation, Mr. Clay returned to work and still earns an income as a longshoreman. Consequently, the extent of the disability associated with his right ankle injury is partial.

Permanent Partial Disability Compensation

Since Mr. Clay has suffered a permanent, partial disability due to his August 28, 1998 right ankle injury, his disability compensation is established under the Act by the provisions of Section 8 (c), 33 U.S.C. § 908 (c). The Supreme Court of the United States in *Potomac Elect. Power Co. v. Director, OWCP*, 449 U.S. 268, 269 (1980) observed that in this section, the Act provides compensation for permanent partial disability in two ways:

> First, if the injury is of a kind specifically identified in the schedule set forth in §§ 8(c)(1)-(20) of the Act, 33 U.S.C. §§ 908(c)(1)-(20), the injured employee is entitled to receive two thirds of his average weekly wages for a specific number of weeks, regardless of whether his earning capacity has actually been impaired. Second, in all other cases, § 8(c)(21), 33 U.S.C.§ 908(c)(21), authorizes compensation equal to two-thirds of the difference between the employee's preinjury average weekly wages and his postinjury wage-earning capacity, during the period of disability.

Although the first 17 subparagraphs address the total loss of a specified limb, an eye or hearing, Section 8(c) (19) provides that partial loss of use of a limb is compensated as a proportional loss of use of the limb. The Benefit Review Board ("BRB" or "Board") and the courts apply the proportionality principle set out by Section 8 (c) (19) for a partial loss of use by indicating the compensation runs for the proportionate number of weeks attributable to the loss of the member at the full compensation rate of two-thirds of the average weekly wage. *Nash v. Strachan Shipping co.*, 15 BRBS 386, 391 (1983), *aff'd in relevant part but rev'd on other grounds,* 760 F.2d 569 (5th Cir. 1985), *aff'd on recon en banc.* Under this schedule of compensation, the injured employee is automatically entitled to a certain level of compensation as a result of his injury and no proof of actual wage-earning capacity is required to receive the specified compensation. *See Travelers Ins. Co.*, 225 F.2d 137 (2d Cir.) *cert. denied* 350 U.S. 913

(1955). As a result, the adjudication of a permanent partial disability under the schedule is based solely on physical factors. *Bachich v. Seatrain Terminals*, 9 BRBS 184, 187 (1978). In determining the appropriate degree (or proportionate) loss of use in a permanent disability compensation case, the BRB in *Peterson v. Washington Metro. Area Transit Auth.* 13 BRBS 891, 897 (1981), stated an administrative law judge is "is not bound by any particular formula when determining the degree of permanent partial disability and that it is within his discretion to assess a degree of disability different from the ratings found by the physicians if that degree is reasonable."

Because Mr. Clay's permanent partial disability involves his right ankle, the computation of the appropriate compensation involves three components. First, since the schedule does not specifically list ankle injury, I must determine the appropriate subparagraph within the schedule to apply. Second, I must fix the degree of Mr. Clay's permanent partial disability due to his right ankle injury. And, third, I must determine and then apply an average weekly wage. Each of these factors has generated an issue in this case.

Issue No. 1 - Appropriate Schedule Subparagraph

According to Section 8 (c) (4), the compensation for the loss of a foot runs 205 weeks. While, under Section 8 (c) (2), the duration of compensation for a lost leg runs much longer at 288 weeks. Just based on these timing provisions, I'd expect a claimant to argue an ankle injury involves the loss of use of a leg; whereas, the employer, who is responsible for the compensation, would favor a finding that the ankle involves the foot. However, in Mr. Clay's case, the parties have taken the opposite positions. Mr. Clay believes his ankle disability relates to his right foot. Stevens disagrees and maintains the ankle injury affects Mr. Clay's leg. This odd juxtaposition becomes understandable considering that both Dr. Lowery and Dr. Jones gave a higher disability rating for the right foot than the right leg.[6]

Turning to the parties respective rationales, Mr. Clay's points out that the Board has consistently treated an ankle injury as an injury to the foot. To the contrary, Stevens suggests that more recent decisions, in the form of two administrative law judge determinations, have adjudicated an ankle injury as part of the leg due to its adverse impact on the leg. Stevens also observes that Dr. Lowery, Mr. Clay's treating physician, clearly considered the ankle injury as part of the leg for impairment purposes.

In resolving this issue, I first find Dr. Lowery's medical opinion has little bearing on this legal determination. Although a highly qualified orthopaedic surgeon, Dr. Lowery has no apparent expertise, or even familiarity, with Section 8 (c) of the Act. Instead, I will turn to judicial authorities for guidance on the appropriate application of the compensation schedule's subparagraphs.

[6]Dr. Lowery determined Mr. Clay had a 3% disability to his leg which equated to a 5% rating for the right foot. Dr. Jones' percentages were 10% for the leg and 14% for the foot.

In that regard, I have considered both administrative law judge decisions[7] presented by Stevens. However, with all due deference to my judicial colleagues, I find more precedential value in the opinions of the appellate judges on the BRB and Circuit Courts of Appeal for the United States. When ankle injuries have been involved in cases before the BRB and the Circuit Courts, those injuries have treated as an injury to the foot. *See, e.g. Cotton v. Army & Air Force Exchange Svcs.*, 34 BRBS 88 (2000); *Frye v. Potomac Electric Power Co.*, 21 BRBS 194 (1988); *Geisler v. Continental Grain Co.*, 20 BRBS 35, 37 (1987)*; ITO Corp. of Baltimore v. Green*, 185 F.3d 239 (4th Cir. 1999).

Another portion of the schedule, relating to amputation of the leg, Section 8 (c) (15) provides further support for considering an ankle injury as an injury to the foot. By enacting Section, 8 (c) (15), Congress decided the amputation of a leg below the knee (which obviously includes the loss of the ankle) is considered to be the equivalent to the loss of a foot; whereas, amputation above the knee represents loss of the leg.[8] Then, by analogy, an injury to the ankle, an area below the knee, is an injury to the foot rather than the leg..

In light of both the appellate court treatment of an ankle injury and the related provisions of Section 8 (c) (15), I consider that the more appropriate schedule subparagraph is Section 8 (c) (4). I specifically find that Mr. Clay's permanent partial impairment to his right ankle is compensable under Section 8 (c) (4) as a partial loss of use of his right foot.

Issue No. 2 - Degree of Disability

The second requisite factor for the adjudication of Mr. Clay's permanent partial disability compensation is the degree of disability associated with his right ankle and correspondingly his right foot. This dispute concerning degree of disability arises because the two physicians who evaluated Mr. Clay's ankle reached different conclusions. Based on his 3% disability rating for Mr. Clay's lower extremity, Dr. Lowery opined he suffered a 5% impairment to his right foot. Dr. Jones reached a higher number of 14% for Mr. Clay's right foot impairment.

Not surprisingly, Mr. Clay contends Dr. Jones' medical opinion on the degree of disability is more probative for two principal reasons. First, based on his training and certification by the American Board of Independent Medical Examiners, Dr. Jones is better qualified than Dr. Lowery to assess the degree of impairment. Second, Dr. Jones considered both Mr. Clay's pain symptoms and his diminished range of motion in finding an impairment of 10 % to Mr. Clay's lower extremity, which corresponds to a 14 %

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[7]One of the cited administrative law judge decisions, *Ely v. Jones Washington Stevedoring Co.*, 32 BRBS 259 ALJ (1998), appears inapplicable factually. In that case, the judge based his decision on a number of injuries from the knee to the ankle, which made the total injury much broader than Mr. Clay's ankle disability. In the other cited administrative law judge decision, *Camm v. Newport News Shipbuilding and Dry Dock*, 23 BRBS 469 ALJ (1990), the judge noted the lack of any opposition from the other party on the issue.

[8]*See Higgins v. Hampshire Gardens Apartments* 19 BRBS 77, 79 (1986)

impairment to his foot. Dr. Lowery limited his rating solely to pain.

Understandably, Stevens favors Dr. Lowery's disability rating of 5%. Dr. Lowery treated Mr. Clay's injured ankle from shortly after his injury through maximum medical improvement. He even performed surgery on Mr. Clay's ankle. Based on his contact with Mr. Clay, Dr. Lowery considered both Mr. Clay's pain complaints as well as the findings during surgery. In addition, while Dr. Jones used ankle instability evidence by pain on the medical aspect as one of the basis for his assessment, Dr. Lowery found no indication of any ankle instability. Mr. Clay never reported any ankle instability. And, Dr. Lowery found Mr. Clay's pain to be on the opposite, or lateral aspect, of the ankle.

As I previously mentioned, I am not bound by the opinion of a particular doctor. *Peterson,*13 BRBS at 891. However, in this case, I believe the disability resolution is best determined through an evaluation of the relative probative weight of the opinions by Dr. Lowery and Dr. Jones. For the following reasons, I conclude that Dr. Lowery's assessment has greater probative value.

First, while I recognize Dr. Jones' training and certification in the area of disability rating, Dr. Lowery is also a well qualified orthopaedic surgeon who had the added advantage of being intimately familiar with Mr. Clay's right ankle. Second, based on that familiarity developed both through his extensive contact with Mr. Clay as his treating physician, and his arthroscopic surgery of the ankle, Dr. Lowery was in an excellent position to provide the best documented and comprehensive evaluation of the ankle.

Third, Dr. Jones examined Mr. Clay only once; whereas, Dr. Lowery provided the treatment for Mr. Clay's ankle from mid-September 1998 through November 5, 1999, including arthroscopic surgery in June 1999. The significance of this difference in documentation becomes apparent when evaluating the basis for the physicians' respective conclusions about the degree of disability.

During his singular exam in February 2000, Dr. Jones noted some decreased range of motion and determined , apparently based on Mr. Clay's subjective complaints, that he had "ligamentous pain" on medial aspect of the ankle. This later finding was significant to Dr. Jones because, while acknowledging the absence of "definitive ligamentous instability," the presence of the medial pain was the basis for his diagnosis of "moderate impairment."

In contrast, a detailed review of Dr. Lowery's extensive treatment notes reveals some similarities with Dr. Jones' observations in the early phases of Mr. Clay's treatment, but markedly different findings by the time Mr. Clay reached MMI on November 5, 1999. In the very first examination in mid-September 1998, less than a month after the ankle injury, Dr. Lowery recorded that maximum area of tenderness was in the interior region of the ankle and Mr. Clay had minimal tenderness over the medial side. In the October 5, 1998, no significant medial tenderness was noted. In February 1999 and March 1999, Dr. Lowery recorded Mr. Clay's discomfort medially and observed some decrease range of motion. By May 1999, Mr. Clay's pain complaint focused on the anterior side of the ankle. Following the arthroscopic surgery, Mr. Clay reported a different type of pain in July 1999. At that time, Dr. Lowery confirmed

tenderness in the "anterior aspect." In August 1999, nearly a year after his injury, Mr. Clay had good range of motion with only mild tenderness upon palpitation. In the final November 1999 examination, Dr. Lowery recorded Mr. Clay's subjective complaints about occasional pain and swelling. But, his examination disclosed "good motion, good strength, and mild tenderness anteriorly and anterior laterally." When asked about the possibility of ankle instability, Dr. Lowery had a more than sufficient documentary basis to state that he never observed any instability in Mr. Clay's ankle. Likewise, as supported by his documentation, Dr. Lowery never heard Mr. Clay complain about any instability. Dr. Lowery's memory was further validated by Mr. Clay's admission that his ankle had not given way since physical therapy.

Thus, on the critical factor of the presence of a medial ligamentous problem after MMI, I consider Dr. Lowery's assessment that no ligamentous instability existed a much better documented conclusion than Dr. Jones' finding stemming from one examination and based on Mr. Clay's pain complaint. As a result, Dr. Lowery's well-founded recollection about the absence of any ligament instability then serves to undermine Dr. Jones' principal basis for including an instability component to his disability rating.

Fourth, in light of the contrast in observations between the two physicians, Dr. Jones' opinion is not as well reasoned because having reviewed Dr. Lowery's treatment and surgery notes, he did not reconcile his observations from his one-time examination with Dr. Lowery's contrary findings and observations recorded over an extensive period of time. On the other hand, after reviewing Dr. Jones' examination report, Dr. Lowery pointed out the discrepancies and rationally chose to base his ultimate conclusion on the firmer foundation of his documented long term treatment of Mr. Clay's ankle. Additionally, Dr. Lowery's assessment is more consistent with all the medical evidence in the record and thus a better reasoned medical opinion.

In summary, due to his better documented and reasoned medical opinion, Dr. Lowery's assessment that Mr. Clay has suffered a 5% foot impairment carries greater probative weight to the extent it outweighs Dr. Jones' finding of a 14% impairment. Accordingly, based on the preponderance of the more probative medical opinion, I find Mr. Clay has suffered a 5 % impairment to his right foot due to his August 28, 1998 work-related ankle injury.

Issue No. 3 - Average Weekly Wage

The final factor in the disability computation for Mr. Clay is establishment of an appropriate average weekly wage. Section 10 of the Act, sets out various means to determine an average weekly wage. However, based on the parities' agreement and Mr. Clay's 1997 income documentation (CX 8), I find Mr. Clay's average weekly wage at the time of his injury in August 1998, without the inclusion of special payments for vacation/holidays and container royalties, was $1,013.28, with a corresponding compensation rate of $675.52. I also find that with the special pay items, the average weekly wage was $1,445.39 with a corresponding compensation rate of $ 835.74 (the maximum allowable compensation at the time).

Having determined these two figures for average weekly wage, the central issue becomes which average weekly wage is applicable to Mr. Clay's scheduled foot disability. Mr. Clay maintains the holding in *Universal Maritime Service Corp. v. Wright*, 155 F.3d 311 (4th Cir. 1998) that special payments are considered wages should be extended to a scheduled injury, allowing inclusion of the special payments in calculating compensation. The court in that case also removed special payments from the average weekly wage for the first year of compensation to avoid the double recovery of the special payments because the claimant had already earned his entitlement to the additional payments prior to his injury. Absent the first year reduction, the claimant would have had at least a partial double recovery due to the special payments. Yet, in Mr. Clay's case, there is no double recovery problem. As a result, since compensation for permanent partial disability is to calculated based on the worker's average weekly wage, it must reflect the worker's pre-injury earning capacity, which includes special payments. The appropriate average weekly wage is $1,445.39, with a corresponding maximum compensation rate of $835.74.

Stevens argues that the *Wright* court's inclusion of holiday/vacation pay and container royalties as wages has no application to a scheduled injury situation because the compensation for permanent partial disability is made without reference to loss of earning capacity. Instead, based on the plain meaning of the Act, the controlling figure should be the average weekly wage at the time of injury, which in Mr. Clay's case on August 28, 1998 amounted to $1,013.28. Additionally, by the time of his accident, Mr. Clay had already earned his special payment benefits for that year and was unable to earn any additional benefits. So, inclusion of the special payments would not accurately reflect his earning capacity at the time of injury. Finally, even though Mr. Clay would have a higher income after his special payments became due the next contract year, there would be no retroactive action available to change his wage at the time of his injury.

Section 8(c) of the Act states that the compensation for permanent partial disability is 66 and 2/3 % of the average weekly wage for the specified number of weeks in the schedule for the respective injury. In turn, Section 10 of the Act, 33 U.S.C. § 910, governs the determination of the average weekly wage, through three alternative methods. All three methods, Section 10 (a), (b) and (c), first determine the injured employee's annual earnings. In addition to actual wages, the annualized earnings also include holiday/ vacation pay, *Sproull v Stevedoring Servs. of America,* 25 BRBS 100 (1991) and container royalties, *Lopez v. Southern Stevedores*, 23 BRBS 295 (1990). Then, under Section 10 (d), these annual earnings are divided by 52 to determine the average weekly wage. Since a myriad of circumstances could cause an employee to have an artificially low income on a particular day or week, this annualized average approach helps to smooth out the potential arbitrariness and inaccuracy of determining income earning capacity with a one day snapshot.

Although Sections 8 (a) (b) (c), and (e) of the Act apply the term "average weekly wage" without distinction in calculating compensation for permanent total, temporary total, permanent partial and temporary partial disability, the United States Court of Appeals for the Fourth Circuit in *Wright*, 155 F.3d 311, has differentiated the term "average weekly wage" in certain cases involving temporary total disability. The court noted that if an injured employee had already earned entitlement to special pay, such as container royalties, prior to his injury, he would receive that benefit whether he continued to work or not. In that

unique situation, the injured employee suffered no loss due to a work-related injury of his ability to receive the special payments for that year. Consequently, the court declined to include special payments in the average weekly wage for the remaining portion of the contract year to avoid essentially a double recovery by the injured employee.

Initially, I note the central issue in *Wright* was whether the definition of "wages" in Section 2 (13) included special payments. As a baseline, the court held that holiday/vacation pay and container royalties were indeed wages that should be included in the Section 10 calculation of average weekly wage, even at the time of injury. That determination is consistent with BRB's treatment of those special payments as includable wages and represents the default position, Then, in only one specific situation, to avoid a double recovery by the injured worker, the *Wright* court went on to adjust the "average weekly wage" for the remainder of the contract year in which the injury occurred if entitlement to the special payments had already vested. So, in light of the *Wright* court's adjudication, I start my analysis with the determination that Mr. Clay's average weekly wage should include his special payments. Then, I must decide whether bifurcation of the average weekly average as set out in *Wright* is applicable to Mr. Clay's claim.

Upon consideration , I find a significant, and sufficient, distinction between claim of the injured worker in *Wright* and Mr. Clay's case and conclude the *Wright* split of the average weekly wage is not applicable to Mr. Clay's claim. In *Wright*, the injured employee was seeking temporary total disability compensation. That claim for total disability, under the provisions of Section 8 (b), focused the *Wright* court's attention on determining the claimant's loss of earning capacity which lead to their assessment of whether the average weekly wage at the time of injury, after vesting of the special payments, accurately depicted his potential loss of earning capacity. However, in Mr. Clay's case, the disability claim involves permanent partial disability under Section 8 (c) (4). As previously noted, permanent partial disabilities are compensated without regard to any resulting loss in earning capacity. *Potomac Electric Power Co. v. Director, OWCP*, 449 U.S. 268 (1980). So, in a case involving a permanent partial disability, even though an injured employee may have returned to full employment as a longshoreman following MMI (as Mr. Clay did) and thus suffered no apparent loss of income earning capacity, the worker still receives the compensation set out by the Section 8 (c) schedule. Obviously, under this statutory permanent partial disability compensation scheme, the double recovery potential, which so bother the *Wright* court, is not an issue. Thus, permanent partial disability compensation is paid without any adjustment to more accurately reflect the loss of wage earning capacity or, in a similar manner, without consideration of whether special payments have already been earned. While the *Wright* decision is very instructive in its determination that special payments are wages for computation of the Section 10 average weekly wage, its subsequent adjustment to the average weekly wage for the first year of temporary total disability compensation does not apply in a case involving a permanent partial disability compensation for a scheduled injury.

In summary, I find the average weekly wage to be applied in Mr. Clay's case to determine his compensation for the permanent partial disability due to his ankle injury must include the appropriate special payments for holiday/vacation and container royalties. Accordingly, the average weekly wage for the payment of Mr. Clay's permanent partial disability compensation is $1,445.39.

Conclusion

Based on my findings, and the parties' stipulations and agreement, Mr. Clay reached MMI on November 5, 1999. As of that date, he is due permanent partial disability compensation for his August 28, 1998 right ankle injury based on a permanent 5% loss of use of his right foot, under the provisions of Section 8 (c) (4) and (19), based on an average weekly wage of $1,445.39.

ATTORNEY FEE

Section 28 of the Act, 33 U.S.C. §928, permits the recoupment of a claimant's attorney's fees and costs in the event of a "successful prosecution." Since I have determined an issue in favor of Mr. Clay, Mr. Gibson is entitled to submit a petition to recoup his fees and costs associated with his professional work before the Office of Administrative Law Judges. Mr. Gibson has thirty days from receipt of this decision and order to file an application for attorneys fees and costs as specified in 20 C.F.R. §702.123(a). Ms. Morgan has ten days from receipt of such fee application to file an objection to the request.

ORDER

Based on my findings of fact, conclusion of law, and the entire record, I issue the following order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

1. The Employer, STEVENS SHIPPING & TERMINAL CO., shall pay the Claimant, MR. LEONARD L. CLAY, compensation for **PERMANENT PARTIAL DISABILITY** due to a permanent 5% loss of use of his right foot caused by an August 28, 1998 right ankle injury, from November 5, 1999, based on an average weekly wage of $1,445.39, such compensation to be computed in accordance with Section 8(c)(4) and Section 8(c)(19) of the Act.

2. The Employer, STEVENS SHIPPING & TERMINAL CO., shall receive credit for all amounts of **PERMANENT PARTIAL DISABILITY** compensation previously paid to the Claimant, MR. LEONARD L. CLAY, as a result of his ankle injury on August 28, 1998.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: January 31, 2002
Washington, D.C.